		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037572

Facility Name: HILLCREST HEALTHCARE CENTER

Address: 777 DRAPER AVE (Number) JOLIET (City) 60432 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3782789

Date of Initial License for Current Owners: 09/15/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,521	3,521	8
9	SNF/PED					9
10	ICF	48,561	1,084		49,645	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,561	1,084	3,521	53,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.70%

D. How many bed-hold days during this year were paid by Public Aid?
630 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/15/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/15/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 3,521

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	163,493	20,769	9,310	193,572		193,572	4,100	197,672			1
2	Food Purchase		198,084		198,084	#REF!	#REF!	(924)	#REF!			2
3	Housekeeping	172,423	27,836		200,259		200,259		200,259			3
4	Laundry	45,447	14,226		59,673		59,673		59,673			4
5	Heat and Other Utilities			121,712	121,712		121,712	202	121,914			5
6	Maintenance	46,702	36,876	39,255	122,833		122,833	12,612	135,445			6
7	Other (specify):*			11,378	11,378		11,378		11,378			7
8	**TOTAL General Services**	428,065	297,791	181,655	907,511	#REF!	#REF!	15,990	#REF!			8
	B. Health Care and Programs											
9	Medical Director			21,300	21,300		21,300		21,300			9
10	Nursing and Medical Records	1,256,338	61,710	356,871	1,674,919		1,674,919	(321,236)	1,353,683			10
10a	Therapy	75,320	3,872	40,353	119,545		119,545	545	120,090			10a
11	Activities	82,639	12,242		94,881		94,881		94,881			11
12	Social Services	215,930			215,930		215,930		215,930			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,630,227	77,824	418,524	2,126,575		2,126,575	(320,691)	1,805,884			16
	C. General Administration											
17	Administrative	165,631		180,000	345,631		345,631	(117,313)	228,318			17
18	Directors Fees											18
19	Professional Services			323,190	323,190		323,190	(227,242)	95,948			19
20	Dues, Fees, Subscriptions & Promotions			29,434	29,434		29,434	(1,410)	28,024			20
21	Clerical & General Office Expenses	124,772	12,425	152,985	290,182		290,182	(16,715)	273,467			21
22	Employee Benefits & Payroll Taxes			396,816	396,816	#REF!	#REF!		#REF!			22
23	Inservice Training & Education			5,825	5,825		5,825	846	6,671			23
24	Travel and Seminar							759	759			24
25	Other Admin. Staff Transportation			5,142	5,142		5,142	2,820	7,962			25
26	Insurance-Prop.Liab.Malpractice			86,400	86,400		86,400	2,941	89,341			26
27	Other (specify):*							41,749	41,749			27
28	**TOTAL General Administration**	290,403	12,425	1,179,792	1,482,620	#REF!	#REF!	(313,565)	#REF!			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,348,695	388,040	1,779,971	4,516,706	#REF!	#REF!	(618,266)	#REF!			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: HILLCREST HEALTHCARE CENTER #0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		2,110	
			0	9,310
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		14,784	
	ELECTRICITY		61,227	
	WATER		45,147	
	CABLE TV - LOBBY		554	
			0	121,712
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,890	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		10,193	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,098	
	ELEVATOR MAINTENANCE & REPAIR		8,088	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,895	
	FIRE SERVICE		7,091	
			0	
			0	
			0	39,255
7	**OTHER**			
	SCAVENGER		11,378	
	SECURITY SERVICE		0	11,378
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,300	21,300

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		1,159	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PURCHASED SERVICES	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 47-2	150,000	
	RN CONSULTANT	XVIII B 38-2	100,000	
	DENTAL SERVICES		3,600	
	PUBLIC AID /MEDICARE CONSULTANTS		100,000	356,871
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		6,966	
	SPEECH THERAPY SERVICES		783	
	OCCUPATIONAL THERAPY SERVICES		3,969	
	THERAPY CONTRACT SERVICES		17,835	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	40,353
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number HILLCREST HEALTHCARE CENTER **#0037572** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	180,000	180,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	22,127	
	ADMINISTRATIVE CONSULTANTS	XIX C	218,000	
	PROFESSIONAL FEES	XIX C	83,063	
			0	323,190
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,650	
	EMPLOYEE WANT ADS	XIX F	10,071	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	10,139	
	LICENSES & PERMITS	XIX F	1,551	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,565	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,308	29,434
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,425	
	EQUIPMENT REPAIR & MAINTENANCE		9,502	
	OUTSIDE CLERICAL SERVICES		100,800	
	PENALTIES / OVERDRAFT CHARGES	VI 18	12,532	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		582	
	TELEPHONE		26,743	
	MESSENGER SERVICE		1,401	
			0	152,985

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	176,109	
	UNEMPLOYMENT COMPENSATION	XIX D	13,070	
	WORKERS COMPENSATION INSURANCI	XIX D	41,331	
	HOSPITALIZATION INSURANCE	XIX D	141,683	
	EMPLOYEE BENEFITS - OTHER	XIX D	24,623	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	396,816
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,825	5,825
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,142	5,142
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		86,400	86,400
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,779,971

Facility Name & ID Number HILLCREST HEALTHCARE CENTER #0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			41,288	41,288		41,288	5,753	47,041			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,926	53,926		53,926	44,242	98,168			32
33	Real Estate Taxes			76,305	76,305		76,305		76,305			33
34	Rent-Facility & Grounds			621,972	621,972		621,972	9,699	631,671			34
35	Rent-Equipment & Vehicles			43,676	43,676		43,676	7,513	51,189			35
36	Other (specify):*											36
37	**TOTAL Ownership**			837,167	837,167		837,167	67,207	904,374			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,542	56,588	172,130		172,130	(10,113)	162,017			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		115,542	148,568	264,110		264,110	(10,113)	253,997			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,348,695	503,582	2,765,706	5,617,983	#REF!	#REF!	(561,172)	#REF!			45

#REF!

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,633)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(924)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(12,532)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,565)	20		28
29	Other-Attach Schedule	4,700			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,754)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(540,418)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (540,418)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (561,172)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HILLCREST HEALTHCARE CENTER

ID# 0037572

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4,700	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,700		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	4,100	0	0	0	0	0	0	0	0	0	4,100	1
2	Food Purchase	(924)	0	0	0	0	0	0	0	0	0	0	(924)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	202	0	0	0	0	0	0	0	0	0	202	5
6	Maintenance	4,700	7,912	0	0	0	0	0	0	0	0	0	12,612	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	3,776	12,214	0	0	0	0	0	0	0	0	0	15,990	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(321,236)	0	0	0	0	0	0	0	0	0	(321,236)	10
10a	Therapy	0	7,756	0	(7,211)	0	0	0	0	0	0	0	545	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(313,480)	0	(7,211)	0	0	0	0	0	0	0	(320,691)	16
	C. General Administration													
17	Administrative	0	(117,313)	0	0	0	0	0	0	0	0	0	(117,313)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(231,200)	0	3,958	0	0	0	0	0	0	0	(227,242)	19
20	Fees, Subscriptions & Promotions	(6,365)	0	0	4,955	0	0	0	0	0	0	0	(1,410)	20
21	Clerical & General Office Expenses	(12,532)	(100,800)	0	96,617	0	0	0	0	0	0	0	(16,715)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	846	0	0	0	0	0	0	0	846	23
24	Travel and Seminar	0	0	0	759	0	0	0	0	0	0	0	759	24
25	Other Admin. Staff Transportation	0	0	0	2,820	0	0	0	0	0	0	0	2,820	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,941	0	0	0	0	0	0	0	2,941	26
27	Other (specify):*	0	0	0	41,749	0	0	0	0	0	0	0	41,749	27
28	TOTAL General Administration	(18,897)	(449,313)	0	154,645	0	0	0	0	0	0	0	(313,565)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,121)	(750,579)	0	147,434	0	0	0	0	0	0	0	(618,266)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,633)	0	0	11,386	0	0	0	0	0	0	0	5,753	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	44,242	0	0	0	0	0	0	0	44,242	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	9,699	0	0	0	0	0	0	0	9,699	34
35	Rent-Equipment & Vehicles	0	0	0	7,513	0	0	0	0	0	0	0	7,513	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,633)	0	0	72,840	0	0	0	0	0	0	0	67,207	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(10,113)	0	0	0	0	0	0	0	(10,113)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(10,113)	0	0	0	0	0	0	0	(10,113)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(20,754)	(750,579)	0	210,161	0	0	0	0	0	0	0	(561,172)	45

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 180,000	CAREPLUS MGMT INC		$	$ (180,000)	1
2	V	19	ADMIN. CONSULTANT FEES	218,000	" "			(218,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	100,800	" "			(100,800)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	10	M/C,PA,PSYCH,RN FEES	350,000	" "			(350,000)	6
7	V	1	DIETARY SALARIES		" "		11,300	11,300	7
8	V	5	ELECTRICITY		" "		202	202	8
9	V	6	REPAIRS		" "		346	346	9
10	V	6	MAINTENANCE SALARIES		" "		7,566	7,566	10
11	V	10	NURSING		" "		28,764	28,764	11
12	V	10a	THERAPY SALARIES		" "		7,756	7,756	12
13	V	17	ADMIN SALARIES		" "		62,687	62,687	13
14	Total			$ 869,200			$ 118,621	$ * (750,579)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CAREPLUS MGMT INC		$ 3,958	$ 3,958	15
16	V	20	DUES/LICENSES/WANT ADS		" "		4,955	4,955	16
17	V	21	OFFICE SALARIES/EXPENSES		" "		96,617	96,617	17
18	V	23	SEMINARS		" "		846	846	18
19	V	24	TRAVEL		" "		759	759	19
20	V	25	TRANSPORTATION		" "		2,820	2,820	20
21	V	26	INSURANCE		" "		2,941	2,941	21
22	V	27	EMPLOYEE BENEFITS		" "		41,749	41,749	22
23	V	30	SL DEPRECIATION		" "		11,386	11,386	23
24	V	32	INTEREST		" "		44,242	44,242	24
25	V	34	OFFICE RENT		" "		9,699	9,699	25
26	V	35	EQUIP RENT/AUTO LEASE		" "		7,513	7,513	26
27	V								27
28	V								28
29	V								29
30	V	10a	THERAPY SERVICES	40,353	CAREPLUS REHABILITATIVE SERVICES		33,142	(7,211)	30
31	V	39	ANCILLARY THERAPY	56,588	" "		46,475	(10,113)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,941			$ 307,102	$ * 210,161	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	34.67	SEE ATTACHED	5.6	9.35	SALARY	17,289	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	34.67	SCHEDULES	5.6	9.35	" "	17,289	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.60	" "	5.6	9.35	" "	13,064	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.60	" "	5.6	9.35	" "	5,360	21-7	5
6	ROMY MACASAET	RN CONSULT.	NURSING	0.60	" "	5.6	9.35	" "	8,444	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	5.6	9.35	" "	12,506	17-7	7
8	ROSLYN INDICH	BKKP	CLERICAL	2.38	" "	5.6	9.35	" "	5,092	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 79,044		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,761	9 FACILITIES	$ 96,016	$ 10,914	53,166	$ 11,300	1
2	5	ELECTRICITY	" "	568,908	13 FACILITIES	2,165		53,166	202	2
3	6	REPAIRS	" "	568,908	13 FACILITIES	3,701		53,166	346	3
4	6	MAINTENANCE SALARIES	" "	568,908	13 FACILITIES	80,966	80,966	53,166	7,566	4
5	10	NURSING	" "	568,908	13 FACILITIES	307,794	307,794	53,166	28,764	5
6	10a	THERAPY SALARIES	" "	568,908	13 FACILITIES	82,996	82,996	53,166	7,756	6
7	17	ADMIN SALARIES	" "	568,908	13 FACILITIES	670,787	670,787	53,166	62,687	7
8	19	PROFESSIONAL FEES	" "	568,908	13 FACILITIES	42,352		53,166	3,958	8
9	20	DUES/LICENSES/WANT ADS	" "	568,908	13 FACILITIES	53,021		53,166	4,955	9
10	21	OFFICE SALARIES/EXPENSES	" "	568,908	13 FACILITIES	1,033,863	768,069	53,166	96,617	10
11	23	SEMINARS	" "	568,908	13 FACILITIES	9,053		53,166	846	11
12	24	TRAVEL	" "	568,908	13 FACILITIES	8,124		53,166	759	12
13	25	TRANSPORTATION	" "	568,908	13 FACILITIES	30,176		53,166	2,820	13
14	26	INSURANCE	" "	568,908	13 FACILITIES	31,470		53,166	2,941	14
15	27	EMPLOYEE BENEFITS	" "	568,908	13 FACILITIES	446,737		53,166	41,749	15
16	30	SL DEPRECIATION	" "	568,908	13 FACILITIES	121,842		53,166	11,386	16
17	32	INTEREST	" "	568,908	13 FACILITIES	473,414		53,166	44,242	17
18	34	OFFICE RENT	" "	568,908	13 FACILITIES	103,790		53,166	9,699	18
19	35	EQUIP RENT/AUTO LEASE	" "	568,908	13 FACILITIES	80,391		53,166	7,513	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,678,658	$ 1,921,526		$ 346,106	25

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 44,242	1
2												2
3												3
4	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,250	975	1/23/06		450	4
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	$9,478.71	2/23/01	450,000	213,229	1/23/06	PRIME+	20,943	5
	Working Capital											
6	CAREPLUS MGMT - CIB BK	X		WORKING CAPITAL	DEMAND	04/95	1,925,000	483,000		PRIME+	31,088	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							1,445	7
8												8
9	TOTAL Facility Related				$9,478.71		$ 2,377,250	$ 697,204			$ 98,168	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,377,250	$ 697,204			$ 98,168	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 67,580	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 71,585	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,005	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 76,305	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	58,377	8
1999	61,241	9
2000	64,403	10
2001	66,911	11
2002	71,585	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HEALTHCARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0037572

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-11-101-003-0000	NURSING HOME	$ 71,585.16	$ 71,585.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,585.16	$ 71,585.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,039 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	132,928		$	1
2					2
3	TOTALS	132,928		$	3

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	6,230	198	31.5	198		2,410	9
10	LEASEHOLD IMPROVEMENTS			1992	48,072	1,525	31.5	1,526	1	17,549	10
11	LEASEHOLD IMPROVEMENTS			1993	33,291	981	31.5	1,057	76	11,098	11
12	LEASEHOLD IMPROVEMENTS			1994	10,172	261	39	261		2,447	12
13	ROOF REPAIR			1995	5,221	134	39	134		1,111	13
14	CONDENSING UNITS			1996	3,924	101	39	101		770	14
15	CEILING TILES			1996	1,334	34	39	34		254	15
16	ROOF REPAIR			1996	8,079	207	39	207		1,527	16
17	DOORS			1997	1,078	28	39	28		183	17
18	WINDOWS & ROOF VENTILATOR			1997	3,572	92	39	92		556	18
19	WINDOWS			1998	12,100	309	39	310	1	1,737	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS			1998	23,693	607	39	607		3,375	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS			1998	155,436	3,985	39	3,985		21,822	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR			1999	70,751	1,814	39	1,814		8,208	22
23	WINDOWS/FLOORING/DOOR			2000	12,169	442	27.5	442		1,608	23
24	CARPETING			2000	2,088	261	10	209	(52)	731	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE			2001	42,268	1,536	27.5	1,537	1	4,179	25
26	FENCE			2001	10,361	691	15	691		1,727	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING			2001	43,148	1,568	27.5	1,569	1	3,441	27
28	ROOF REPAIRS/HEAT/AC REPAIRS			2002	12,346	450	27.5	449	(1)	632	28
29	FENCE			2002	4,573	305	15	305		457	29
30	DOOR REPLACEMENTS/DUCTWORK-FIRE CODE			2003	7,297	179	27.5	179		179	30
31	WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS			2003	66,500	886	27.5	886		886	31
32	DURO-LAST ROOF SYSTEM			2003	92,265	907	27.5	907		907	32
33	FENCE / PARKING LOT SEAL			2003	8,816	294	15	294		294	33
34											34
35											35
36	RELATED PARTY ALLOCATION - CAREPLUS MGMT					110		110			36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 684,784	$ 17,905		$ 17,932	$ 27	$ 88,088	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 194,158	$ 18,596	$ 16,153	$ (2,443)	8-15 YRS	$ 88,330	71
72	Current Year Purchases	10,735	4,897	1,680	(3,217)	8 YRS	1,680	72
73	Fully Depreciated Assets	35,826				5-8 YRS	35,826	73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 11,276		11,276	11,276				74
75	TOTALS	$ 240,719	$ 34,769	$ 29,109	$ (5,660)		$ 125,836	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 925,503	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 52,674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 47,041	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,633)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 213,924	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: DRAPER PLAZA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		168	9/15/91	$ 621,972	15		3
4	Additions							4
5								5
6								6
7	TOTAL		168		$ 621,972 **			7

10. Effective dates of current rental agreement:
Beginning 9/15/91
Ending 9/15/16

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 34,796 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY/HSKP/	FACILITY FORD VAN	$ 683.10	$ 8,880	17
18	MAINT				18
19					19
20					20
21	TOTAL		$ 683.10	$ 8,880	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 44,483	$		$ 44,483	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			918			918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			11,187			11,187	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				108,018		108,018	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3								12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					7,524		7,524	13
14	TOTAL			$		$ 56,588	$ 115,542		$ 172,130	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,378	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 90,000)	1,057,061		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,482		6
7	Other Prepaid Expenses	45,653		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): R.E.TAX ESCROW	50,450		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,297,024	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	684,784		15
16	Equipment, at Historical Cost	240,718		16
17	Accumulated Depreciation (book methods)	(294,623)		17
18	Deferred Charges	975		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEP	1,366		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 633,220	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,930,244	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 518,723	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	696,229		29
30	Accrued Salaries Payable	103,430		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,231		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,398,913	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,398,913	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 531,331	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,930,244	$	48

*(See instructions.)

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 179,899	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 179,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	351,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 351,427	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 531,331	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,965,410	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,965,410	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,000	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,000	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,969,410	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	907,511	31
32	Health Care	2,126,575	32
33	General Administration	1,482,620	33
	B. Capital Expense		
34	Ownership	837,167	34
	C. Ancillary Expense		
35	Special Cost Centers	172,130	35
36	Provider Participation Fee	91,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,617,983	40
41	**Income before Income Taxes (line 30 minus line 40)****	351,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 351,427	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,332	4,598	$ 121,479	$ 26.42	1
2	Assistant Director of Nursing	44	46	1,224	26.61	2
3	Registered Nurses	13,338	14,233	322,380	22.65	3
4	Licensed Practical Nurses	19,316	20,687	402,153	19.44	4
5	Nurse Aides & Orderlies	41,143	45,795	388,798	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,164	7,291	75,320	10.33	8
9	Activity Director	2,017	2,100	37,362	17.79	9
10	Activity Assistants	6,422	7,042	45,277	6.43	10
11	Social Service Workers	13,336	14,121	215,930	15.29	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,180	28,377	13.02	13
14	Head Cook	5,799	6,589	51,788	7.86	14
15	Cook Helpers/Assistants	12,236	13,227	83,328	6.30	15
16	Dishwashers					16
17	Maintenance Workers	3,618	3,972	46,702	11.76	17
18	Housekeepers	23,433	25,385	172,423	6.79	18
19	Laundry	5,549	6,303	45,447	7.21	19
20	Administrator	2,399	2,627	82,469	31.39	20
21	Assistant Administrator	4,869	5,143	83,162	16.17	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,431	7,993	124,772	15.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,853	1,960	20,304	10.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,281	191,292	$ 2,348,695 *	$ 12.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	21,300	9-3	36
37	Medical Records Consultant	N	2,112	10-3	37
38	Nurse Consultant	T	100,000	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC/MENTAL HEALTH		150,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 291,412		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFFREY KALKOWSKI	ADMIN	0	$ 79,552
ELLEN TIERNEY	ADMIN	0	2,917
JEFFREY BAKER	ASST ADMIN	0	83,162
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,631

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 180,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 13,200
AMERICAN DATA	DATA PROC	2,429
NATIONAL DATACARE	DATA PROC	3,270
ACHIEVE	DATA PROC	3,228
KBKB	ACCT	28,950
MEYER MAGENCE	LEGAL	3,301
WINSTON & STRAWN	LEGAL	35,431
PERSONNEL PLANNERS	UNEMPL CONSULT	1,759
ECONOCARE	PURCHASING CONSULT	2,772
CAREPLUS MGMT	ADMIN CONSULT	218,000
RICHARD PEELO	M/C COST REPORT	5,850
CIB BANK APPRAISAL	APPRAISAL	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 323,190

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 41,331
Unemployment Compensation Insurance		13,070
FICA Taxes		176,109
Employee Health Insurance		141,683
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		24,623
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,071
Health Care Worker Background Check	1,308
(Indicate # of checks performed 72)	
MARKETING/ADV/PROMO	6,215
TRUST/FRANCHISE/CONTRIB/ETC	150
LICENSES & PERMITS	1,551
DUES & SUBSCRIPTIONS	10,139
MGMT CO ALLOCATION	4,955
TRUST/FRANCHISE/CONTRIB/ETC	(150)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,650)
Yellow page advertising	(1,565)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,024

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	0
MGMT CO ALLOCATION	759
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 759

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2001	$ 7,075	3	$	$ 1,180	$ 2,358	$ 2,358	$ 1,179	$	$	$	$
2	PAINT/DECORATING	2002	7,025	3			1,171	2,342	2,342	1,170			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,100		$	$ 1,180	$ 3,529	$ 4,700	$ 3,521	$ 1,170	$	$	$

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8,770**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,262** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **91,980**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees